To: The Oregon Universal Health Care Task Force  March 31. 2022
From: Mike Huntington MD
Re: Comments by Daniel Deitz, LPRO Analyst

Dear Task Force Members,

The article below is to balance the overly optimistic portrayal of Direct Contracting Entities and ACO-REACH.

CMS Dumps DCEs … In Name Only
From the February 28, 2022 Health Justice Monitor
http://healthjusticemonitor.org/2022/02/28/cms-dumps-dces-in-name-only/

**Summary:** CMS apparently took to heart concerns about the privatization of traditional Medicare with DCEs, pivoting to a new program ACO REACH focused on equity and disparities. Except that the new program is really no different than DCEs. Re-branding while continuing the march to corporate control of Medicare won't cut it.

ACO-REACH
CMS February 2022

The Centers for Medicare & Medicaid Services (CMS) has redesigned the Global and Professional Direct Contracting Model (GPDC) Model in response to Administration priorities, including our commitment to advancing health equity, stakeholder feedback, and participant experience. CMS is renaming the model the ACO REACH Model to better align the name with the purpose of the model: to improve the quality of care for people with Medicare through better care coordination, reaching and connecting health care providers and beneficiaries, including those beneficiaries who are underserved, a priority of the Biden-Harris Administration.

Comparing DCE to the ACO REACH
CMS February 2022 A very detailed side-by-side table.

'Band-Aid on a Tumor': Biden Rebrand of Trump's Medicare Privatization Scheme
February 25, 2022. By Jake Johnson. PNHP (Physicians for a National Health Program)—which has implored the Department of Health and Human Services (HHS) to fully halt the program—outlined how the revamped pilot "perpetuates the dangerous flaws" of the Trump administration's Direct Contracting experiment:

* Like the DC model, ACO REACH will pay middlemen a flat fee to "manage" seniors' health, allowing them to keep 40% of what they don't spend on care as profit and overhead.
* Traditional Medicare beneficiaries will still be automatically enrolled into ACO REACH entities without their full understanding or consent, and once enrolled cannot opt out of an ACO REACH entity unless they change primary care providers.

* Like DCEs, the ACO REACH program has virtually no limits on what type of company can participate; entities can be owned by commercial insurers, private equity investors, and other profit-seeking firms, including current Direct Contracting entities.

* The new program increases provider governance from 25% to 75% (with loopholes built into the application process), but ACO REACH entities are ultimately accountable to investors.

"**Changing the name** doesn't change the fact that the Direct Contracting program is backdoor privatization of Medicare," Alex Lawson, executive director of Social Security Works, said in a statement. "This dangerous experiment must be stopped before it further harms the health of vulnerable seniors, eats into the Medicare Trust Fund, and destroys traditional Medicare."

**It's all very similar to Medicare Advantage.** See HJM's earlier posts on DCEs: How Corporate Investors Deplete Medicare and CMS Direct Contracting Scheme Will Privatize Medicare. Here are a few key problems with this re-branding:

Profiting from reduced care: As PNHP points out, both DCEs and REACH ACOs potentially retain 40% of medical care costs not incurred. But it's actually worse than that – they retain 100% of the first 25% drop in spending. If they reduce care costs for a Medicare beneficiary from $10,000 to $7,500, they keep the entire savings of $2,500. (There's a small "discount" to these savings for part of the program, to let CMS keep a tiny portion … and that's being trimmed, to the benefit of corporate participants.)

**Less focus on care quality:** The "quality withhold" for failing to meet quality criteria is dropping from 5% to 2%. Less incentive to provide quality. Risk Adjustment Manipulation: While there are some limits on upcoding of clinical severity, there are also exemptions and workarounds to permit the DCEs/ACOs to continue to game the system by bumping up apparent clinical severity and thus payments from CMS.

**Ineffective Oversight:** The REACH ACOs mandate provider and beneficiary roles in oversight, but with such loose definitions (eg of "provider") and minimal participation (eg, one beneficiary on an oversight board) that control will remain with corporate investors and executives. Likewise, monitoring requirements (eg access to care) are vague and prone to manipulation and disregards given the history of CMS corporate favoritism.

Why does CMS believe that shifting fee-for-service Traditional Medicare to something like Medicare Advantage will save money for Medicare and protect beneficiaries, when Medicare Advantage never has? (nor have ACOs)

Michael C. Huntington MD
9083 NW Lessie Place
Corvallis, Oregon 97330
541-829-1182

mchuntington@gmail.com